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Can We All Fit?

Squeezing in Better Support With Fewer People

As Mary drives away from her home visit with Alex, she can not get Mrs. Clanton's words out of her mind. Normally Mrs. Clanton is so attentive to what Mary is doing with her two-year old, Alex, but the family is having a stressful week. And, in addition to seeing Mary, a special instructor, Alex sees a speech therapist, physical therapist, occupational therapist, neurologist, gastroenterologist, and an ophthalmologist. By the end of the week, Alex and his mother have been seen by seven different professionals, each with a different focus. Mrs. Clanton is overwhelmed by all of the appointments and information. During the home visit she began to cry and remarked, "I feel like a secretary and a taxi. My life is consumed with Alex's appointments. The days early intervention comes to me are much better because at least I don't have to go to an office and wait for hours, but it still isn't a normal life. In the past month there were only three days that we didn't have an appointment with someone for Alex. I know Alex has a lot of needs, but I need for us to just be a family some of the time."

The words echo in Mary's head as she drives. She has been so thankful that Alex lives in an area where there is no shortage of therapists so he can receive plenty of services. Now she begins to wonder how much good comes from all of the team members visiting each week. But how could fewer people visit—and visit less often? Alex has a diagnosed disability that affects him significantly in multiple developmental areas.

Alternative Approach to Team Configuration

Research indicates that when more people are on the team, families may feel less supported, and diminished child outcomes can result (Dunst, 1999). However, trimming the team can be a sensitive issue to address. After all, there is no available research that clearly indicates either the optimal number of people on the team or the optimal frequency of visits. Furthermore, each potential team member has valuable expertise and knowledge. Although the literature is supportive of narrowing early intervention teams to a primary service provider with other members in supportive roles (e.g., McWilliam, 2000a), arriving at the specific decisions that lead to this type of team configuration can be challenging. So how do teams find a balance between providing enough support but not too much? There are also obstacles that may be imposed upon teams from people outside early intervention. Questioning the value of a specific service or services, for example, when a physician has *written a prescription for a patient* to receive multiple therapeutic interventions each week, may be uncomfortable for an early intervention provider.

Individualized Family Service Plan (IFSP) teams are by definition comprised of professionals from a variety of disciplines who are trained to determine recommendations for the services they deliver (IDEA, 1997). Service coordinators have the sometimes arduous job of facilitating a decision-making process that integrates these recommendations into a cohesive plan that is meaningful for families and best supports and enhances the overall development of the child. This article describes an alternative approach for determining who is on the team from the approach presently in use by many early intervention programs. A brief description of a commonly-used model is provided, followed by a discussion of the frequently raised concerns to adopting an alternative approach and a presentation of the arguments to address these concerns.

A Common Approach of Deciding Team Configuration

What are the areas of concern for the child and family? Which team members address those areas of concern? These questions, relying heavily on evaluation and assessment results, are commonly used in determining team configuration and, at first glance, may seem logical to ask when deciding who supports a family and delivers the services. As illustrated by Figure 1, this method involves conducting evaluation and assessments, determining the area(s) of need highlighted in the evaluation and assessments, and choosing a service to address each area of need. Therefore, if a child has a communication delay, the child would likely receive speech and language therapy and possibly special instruction. Using this process

Figure 1
Evaluation and Assessment-Guided Service Decisions

every child a team sees who has a communication delay may receive speech and language therapy, *every* child with a gross motor delay may receive physical therapy, and so on.

This approach may seem to some team members like a reasonable means to select appropriate services, but this problem-centered focus can lead to more services than are necessary or helpful for a family. Furthermore, if a primary service provider model is not used, multiple people on the team might each schedule a weekly visit. Consider a child who has developmental delays in several areas. If all disciplines qualified to address each area of delay came each week, the family might have to plan every week around four or five home visits.

An Alternative Model of Support

The alternative model proposed in this article is not a new approach. Researchers in the field of early intervention have stressed for years the need for linking service decisions to outcomes, which should be derived from family priorities, concerns (Harbin et al., 1998), and routines (Cripe & Venn, 1997; McWilliam, 2000b). Researchers also have discussed the value of a primary service provider model (Kochanek & Buka, 1998) that makes good use of consultative service delivery (File & Kontos, 1992; Hanft & Pilkington, 2000) or coaching (Hanft, Rush, & Shelden, 2004). Although many service providers in the field indeed use these strategies to determine team configuration, and a mounting number of states are adopting policies that support these strategies, research examining practices (McBride & Peterson, 1997), perceptions (Campbell & Halbert, 2002), and the IFSP process and documents (Harbin et al., 1998; Jung & Baird, 2003) indicates these strategies are not used as often as they could be. In many cases a heavy reliance on evaluation and assessment instruments to make service decisions may still be in place (Harbin et al., 1998). One reason that the older model is still lingering may be in part due to concerns that some providers have about the newer practices.

Addressing Concerns With an Alternative Approach

Although research and recommended practices support the use of an alternative approach to making decisions about who is on the team, some service providers continue to express concerns that may preclude their confidence in using an alternative approach. Campbell and Halbert (2002) surveyed 241 providers on changes they would like to see to improve early intervention quality. Among other "wishes" compiled by the researchers, service providers expressed a need for more services; a return to center-based programs; and for families to participate more, follow through more, and to have more education on child development. Some of these providers may have considered more frequent services and center-based services as solutions to concerns they had with parent follow through, participation, and knowledge of child development.

Let's consider how an alternative model may be able to address two primary concerns identified by service providers: (1) low levels of family participation and follow through with early intervention activities and services; and (2) concern that specific interventions are too specialized for implementation by adults who are not appropriately trained and/or credentialed.

Addressing a Concern About Family Participation and Follow Through

A team can be concerned that the family might not follow through with intervention suggestions (Bernheimer & Keogh, 1995). Based on this concern, service providers may think the child needs to be visited frequently by each team member to provide "insurance," so to speak, in case the family does not follow through. While well intended, the providers may unknowingly send messages to the caregiver that actually *decrease* rather than increase follow through. When many professionals visit frequently, the caregiver can come to believe that only these professionals can make changes in the development of the child. If caregivers believe they have little power to enhance the development of their child, they have no reason to participate or follow through. If they feel the professionals are the only ones with the skills and power to make meaningful positive changes in their child's development, they will likely see direct intervention by all team members as valuable (Jung, 2003), even if they find the multiple, frequent visits to be disruptive to their lives.

Neither more people on the team nor more visits equal more intervention. Most of the intervention occurs between service visits (McWilliam, 2000b). In other words, information exchange and support that happen during visits between the service providers and the caregiver pave the way for the *real* intervention to occur every day. Because changes in children's development are affected by multiple, interest-based learning opportunities (Dunst, Herter, & Shields, 2000) throughout the day (Losardo & Bricker, 1994) in meaningful contexts (Horn, Lieber, Li, Sandall, & Schwartz, 2000; Venn et al., 1993), it is unlikely that four to five people visiting each week would improve child development any more than one person visiting each week. If the strategies suggested are consistent with family routines (Bernheimer & Keogh, 1995), are directly and explicitly linked to outcomes that families have requested, and families understand they have the power to make changes in their child's development, then this type of service delivery can work, and work better—even with complicated intervention strategies.

Addressing a Concern That Certain Interventions Are Too Specialized

Professionals may be concerned that teaching a family certain strategies is not appropriate because parents are not trained in providing intervention (Bernheimer & Keogh, 1995) and do not have a full understanding of child development (Campbell & Halbert, 2002). They may believe, therefore, that intervention will be more effective if all professional team members visit and provide direct services. Consider, though, that some years ago the medical profession recognized the abilities of families to care for their children and began training parents on medical procedures necessary for the survival of children with complex health care needs. Parents mastered the ability to suction tracheotomy tubes, feed their children via gastrostomy tubes, and monitor for and respond to bradycardia and apnea episodes (Seitz & Provence, 1990). These procedures are, for the most part, much more complicated than the average intervention suggested by a therapist or educator, and the child's life often depends on the parent's ability to do these procedures correctly.

Although some of the strategies suggested in early intervention may in fact be very complicated, families can be given the support they need to be able to use the strategies needed to meet the outcomes. Such support may involve more frequent visits for a short period of time, phone calls from the interventionist, or more frequent consultation with the primary service provider.

Implementing an Alternative Approach for Determining Team Configuration

As described, an alternative process that makes use of a primary service provider incorporating a consultative and routines-based service delivery approach may in fact be a very effective method for providing intervention to a child by supporting the family's competence, confidence, and follow through. In order to implement such an approach the team must decide upon the appropriate team configuration for the delivering of services. First, the question of which person on the team is the most appropriate to serve as the primary service provider is addressed. Second, the question of which professional disciplines are needed to support the primary service provider relative to each outcome is answered.

Choosing a Primary Service Provider

On any given IFSP team there will likely be more than one person who is appropriately qualified and could adequately serve in the role of primary service provider. Because the primary service provider will be supported as appropriate by other members of the team, the discipline of the primary service provider is not of primary importance. All service providers in early intervention should have core knowledge of child development and effective intervention strategies, as well as competence in working with families to support family ability and confidence in implementing interventions.

We can borrow from the field of managed care to reflect on how families choose primary health care providers. Qualifications are important, but it is generally assumed that all providers in a network are qualified. Rather, the Society of Primary Care Policy Fellows encourages consumers to choose a health care provider by considering the following: accessibility, accountability, comprehensiveness, continuity, and coordination (Cary, Burnett, & Onieal, n.d.). Using these same five aspects, Table 1 (see following page) presents some questions the family, together with the members of the IFSP team, can ask when choosing a primary service provider. Because providers' qualifications are assumed, some of the important questions in choosing a primary service provider include issues such as family comfort with the provider, provider planning based on family priorities, provider location, compatibility of provider and family schedules, commitment to remain in the system and area, and knowledge of community resources. Though choosing a primary service provider in early intervention does not exactly mirror the health care field, examining elements of the decision-making process in the field of managed care can help teams choose a primary service provider based on who, for a variety of reasons, makes sense for the family rather than basing the decision primarily on discipline and child needs or deficits.

Neither more people on the team nor more visits equal more intervention.

Table 1
Considerations in Identifying a Primary Service Provider

Consideration	Sample Questions
Accessibility	Is the location convenient? Can I be worked into the schedule easily? Does the provider speak my language? Do I, in general, feel comfortable with the provider?
Accountability	Does the provider have expertise in primary care? Does the provider communicate in language I can understand? Does the provider seek education beyond licensure requirements? Does the provider avoid duplication of services?
Comprehensiveness	Can this provider address the majority of my needs? Will the provider refer to others if needed?
Continuity	How long has this provider been with the practice or in the area? Does the provider have a commitment to remain in the area? How knowledgeable is this provider of community resources?
Coordination	How well can this provider integrate information and recommendations from other providers? Does this provider make decisions based on my priorities? Does this provider give me a voice in decision making?

Note: The content of this table was adapted from Cary, Burnett, and Onieal (n.d.).

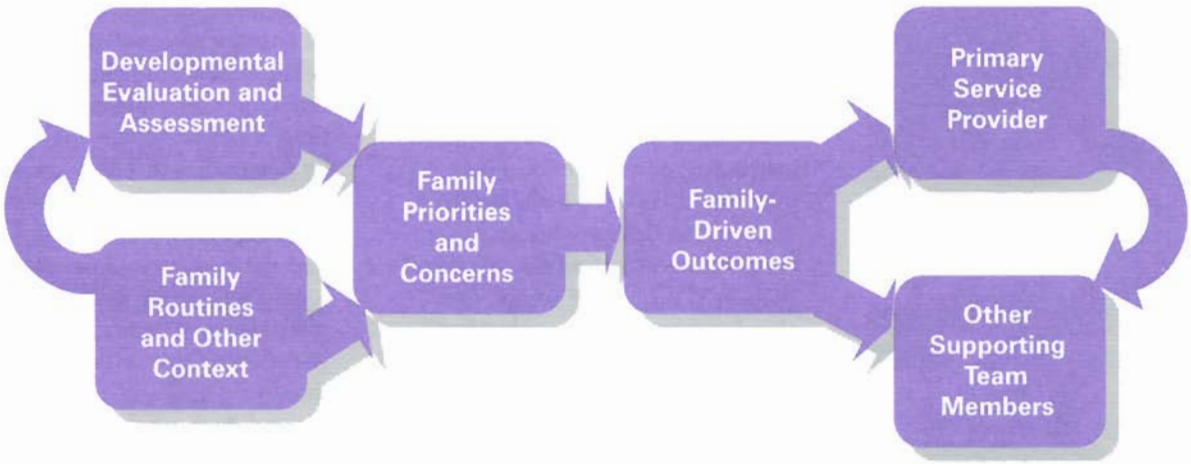
Who Is Needed to Support the Primary Service Provider?

Although evaluation and assessment information can in part inform decisions on services, questions about family priorities, concerns, and routines should be systematically included in the decision-making process (Bernheimer & Keogh, 1995; Cripe & Venn, 1997; McWilliam, 2000a). Just as family priorities, concerns, and routines help to determine outcomes and strategies, they should also play a role in determining services. An alternative to the current service decision-making process includes an approach in which decisions on outcomes and services are interrelated.

In this approach, as illustrated in Figure 2, the direct line between evaluation/assessment and services is broken, and a clear family role is inserted. Teams share evaluation and assessment information with families; discuss with families their priorities and concerns; develop with families outcomes that directly respond to family priorities and concerns; and only after family-driven outcomes are developed, determine with families the team members needed to support the outcomes. Much of the decision on which services are needed cannot be decided until a primary service provider is chosen.

After teams agree on a primary service provider, they think strategically about how to cover all outcomes and strategies with the minimum number of people

Figure 2
Outcome-Guided Service Decisions



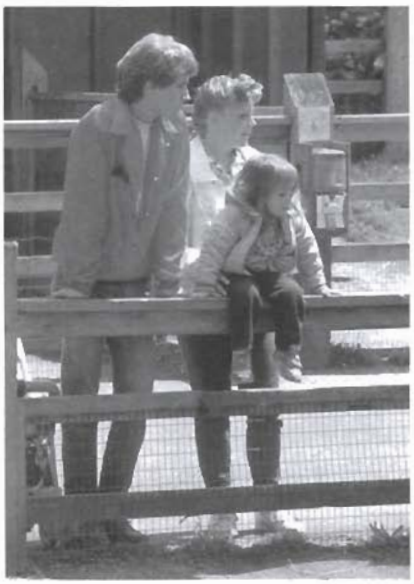
necessary. To do this, outcomes are reviewed and discussed to determine in which areas the primary service provider needs additional support.

Mary, a special instructor, is selected as the primary service provider for Alex. She feels very comfortable supporting many of the strategies on the IFSP, crossing all developmental domains. The IFSP team feels that Mary needs additional support for the strategies on positioning. For this intervention the physical therapist designs strategies that are then demonstrated to the caregivers and to Mary. Although the special instructor did not have the expertise to *design* this intervention, she does, however, have core knowledge of child development and is present during sessions in which the strategy is demonstrated.

Thus, Mary is fully capable of supporting the family in using this intervention. All other members of the team are available to provide additional support when needed.

As the intervention requires change to meet the family's outcomes, the physical therapist will return to assess and modify the existing intervention or to design a new one. Additionally, the speech therapist on Alex's team comes in to address a specific issue related to Alex's emerging expressive language that the family and Mary have observed and would like some help addressing. Yet, the family builds a relationship with the primary service provider, in this case Mary, the special instructor, and information and ideas are funneled through that one person.

After teams agree on a primary service provider, they think strategically about how to cover all outcomes and strategies with the minimum number of people necessary.



Following this approach, there may be many families who have children with delays, for example, in communication, who receive support from a speech/language pathologist but not from a special instructor, or vice versa. There may be others who have children with motor delays who do not receive ongoing, frequent physical therapy. This can be uncomfortable for team members, but by carefully reviewing each outcome and strategy, teams can make certain all necessary areas of support are covered but without "service overkill." When this approach was implemented with Alex's family, his mother no longer felt that her life was consumed with appointments. Her priority to spend more time just being a family was acknowledged and addressed by the team.

Conclusion

When service decisions are made in a way that focuses on routines-based, consultative service delivery; family-driven outcomes; and a primary service provider, families receive a package of coordinated services that is much greater than just those individual services. In other words, when early intervention services are delivered in this manner, the whole is greater than the sum of its parts.

Though her name was changed, Mrs. Clanton's story is a true one. After hearing her remarks, her service coordinator helped the team think through team configuration decisions. Her pediatrician did the same for the medical team. Each of the IFSP team members agreed that they all had core knowledge of child development and through planning and communicating together, they could serve the Clanton family better and in a less intrusive manner. Mrs. Clanton decided to build upon the relationship she had with Mary by having her visit once each week, with the therapists visiting the family jointly with Mary less frequently. She then only had one visit to plan around each week. Some months later, in talking to her service coordinator, Mrs. Clanton said, "I had to decide what was necessary and what was extra. I could not live that way any longer. It wasn't easy, but if I hadn't cut out some of the appointments I would have had a child with a disability *and* a nervous breakdown."

Instead of assuming that larger teams automatically equal greater support for families and better outcomes for children, teams can use two questions to begin to think more systematically about how to design service delivery that makes sense for individual children and families. By using the decision-making process described in this article in conjunction with other family-centered practices, teams can hopefully arrive at a sensible team configuration—not too little, not too much, but just enough.

Note

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... [B]y carefully reviewing each outcome and strategy, teams can make certain all necessary areas of support are covered but without "service overkill."

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